

**Her Choice Midwifery Services**

1300 Franklin Ave. Suite 270

Normal, IL 61761

Ph (309) 585-3535

Fax (309) 740-4108

**Billing Terms and Conditions**

Good relationships can only be established with mutual understanding. Therefore, we encourage our patients to discuss any question they have regarding the following policies.

Her Choice Midwifery Services participates with numerous health care insurance plans. For patients that are members of one of these plans, our business office will submit a claim for provider services rendered and will follow-up with that insurance until resolved. We do not accept Medicare or Medicaid as a primary or secondary insurer.

Non-contracted insurances plans will be billed as a courtesy, however the charges as well as the follow-up with the insurance plan becomes the patient’s responsibility if the insurance does not respond within 30 days.

If you do not have health insurance, all fees are payable at the time of your visits.

Your medical insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your medical claims by your insurance company does not relieve the financial obligation you have incurred with Her Choice Midwifery Services.

Please be prepared to show your insurance card at each visit.

Insurance co-payments are expected at the time of service.

All patient balances are due and payable within 30 days after the insurance payment has been received.

It is the patient’s responsibility to ensure that the required referrals be provided prior to the visit. Visits may be rescheduled or the patient may be financially responsible due to the lack of appropriate referral.

Prepayment may be required for services not covered by insurance or in cases of high dollar deductible amounts.

A late payment charge of $10.00 per month will be added to any account that has aged 30 days. The late payment charge will be billed each month and will appear separately on your statement.

Her Choice Midwifery Services accepts MasterCard, Visa as well as personal checks and cash. The fee for a returned check is $25.00.

Unpaid balances may be turned over to a collection agency after 90 days. The patient is responsible for collection costs including agency fees, attorney fees, and any costs incurred by Her Choice Midwifery Services.

Her Choice Midwifery Services reserves the right to terminate a patient due to the breakdown of the provider/ patient relationship caused by excessive failed appointments, medical no-compliance, inappropriate conduct or failure to keep their account in good standing.

If you need assistance in understanding your Her Choice Midwifery Bill, please contact the billing department at 309-585-3535 option #2.

\_\_\_\_\_\_ **Finance Charge Authorization**

Initials A late payment charge of $10.00 will be added to an account if payment is not made on patient’s responsibility charges within 30 days. The late payment charge will be billed each month until those charges are paid in full and will appear separately on your regular statement.

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Initials **Authorization to Release Information for Treatment, Payment and/or Healthcare Operations**

I authorize Her Choice Midwifery Services and its providers to release any information regarding the medical, treatment including HIV/AIDS and disability related information to any third party payer, or to their contracted agents to validate or determine benefits payable for services rendered to myself or any dependents.

\_\_\_\_\_\_\_ **Billing Terms and Conditions**

Initials My initials and signature acknowledges that I have read and understand Her Choice Midwifery Services billing terms and conditions.

\_\_\_\_\_\_\_ **Notice of Privacy Practices**

Initials My initials and signature acknowledges that I have been offered a copy of of Her Choice Midwifery Services Notice of Privacy Practices.

\_\_\_\_\_\_\_ **Billing for Services Rendered**

Initials My initials and signature acknowledges that I understand I am financially responsible to pay for any services that are rendered.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_